



2026 BU-NHS Conference

# Moving Forwards Together

Fusion Building, Talbot Campus  
16th April 2026



MORNING BREAK



2026 BU-NHS Conference

# Moving Forwards Together

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Programme B  
INSPIRE

# URGENT RESPONSE NON-INJURY FALLS

## Aim of the project:

To test whether a therapy-led response to non-injury falls can:

- Provide faster support for patients
- Improve clinician confidence and enhance practice within OT/PT workforce
- Strengthen joint working across services
- Reduce ambulance disposition and conveyance to hospitals

**Stacey Way- Clinical Service Development Lead, DHC**

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# Did you know?



Dorset has the highest delayed response rates for Category 3 fallers



Long lies can cause dehydration, pressure ulcers, muscle damage and psychological distress



Admission/treatment/investigations at hospital can cost from £173-£563



Average cost of ambulance call out = £327 and £459 if then transported to ED



NHS priority; reduce avoidable admissions through stronger community and neighbourhood teams

## Why is the project needed?

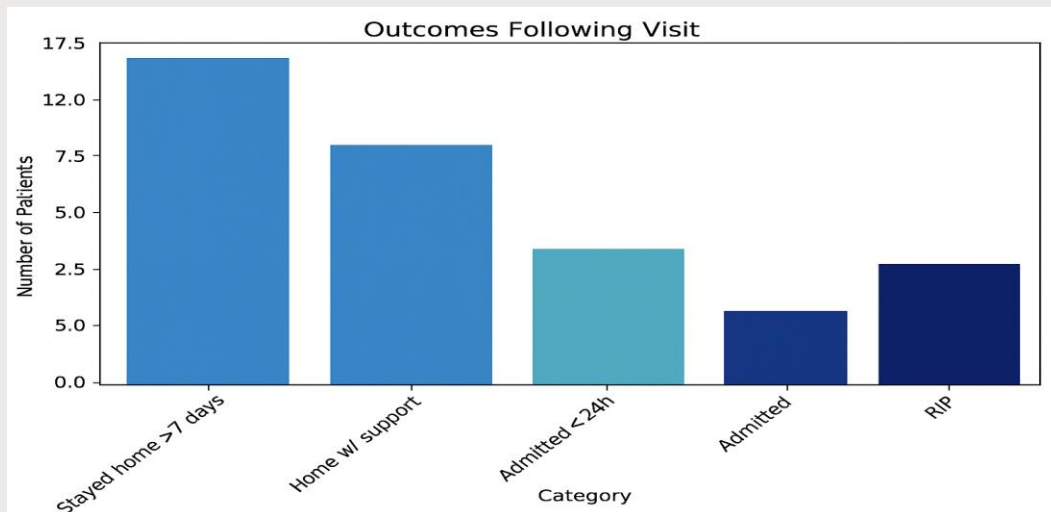
- The demand on UCR to respond to 2 hour non-injury falls from 111 and 999. In the last 8 months 1312 referrals re: falls (30% of all referrals into UCR). UCR completed 899 face to face visits. = 68% visits
- Recognition therapy could greatly improve falls response, but differing competencies and confidence across localities have reduced ability to support UCR falls
- Risk to patients if on the floor for long periods of time
- Opportunities to work as an integrated team in responding to fall and increase capacity
- Seamless transition for patients between services- improvement of education and awareness of pathways

# The pilot and results



## Covering East & West Dorset

- 1 UCR therapist
- 1 ICRT therapist
- Support from a UCR triage clinician when medical concerns were identified



## Results (12 days)

- 27 patients seen (UCR falls or ICRT admission avoidance)
- 21 avoided hospital admission
- Of this, 13 patients were supported by community services
- Of the 27 patients; 18 managed fully by the attending clinicians with no escalation needed to a medical clinician
- 2 patients were admitted
- 6 have since died, reflecting the frailty and complexity of this group

## Qualitative results from Clinicians involved:

- Strengthened inter-team relationships
- Increased confidence in supporting fallers and clinical knowledge
- Improved understanding of each service's role



## Next steps following the project

- Develop clear governance & competency frameworks
- Provide training & education
- Test the model across other ICRT/ICT Teams and collate feedback
- Continue data collection for wider rollout
- Consideration of how to embed 2-hour UCR response into daily capacity for all teams

### Future Ambition:

For non injured falls to become everyone's business across Dorset HealthCare

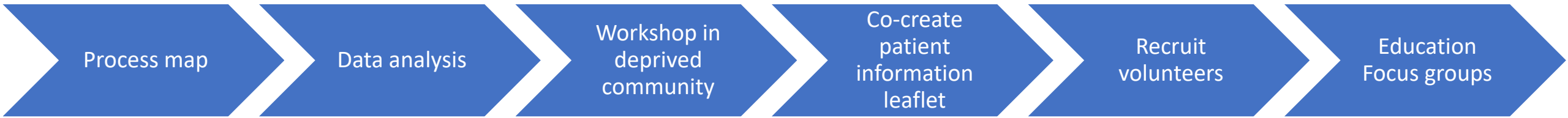
Improving quality, service delivery and patient experience in a rural, coastal, community based pulmonary rehabilitation service: A quality improvement study.

Naomi McKnight  
Band 7 Physiotherapist



**Dorset County Hospital**  
NHS Foundation Trust

# What challenges affect access to pulmonary rehabilitation for patients living on Portland?



You said,

Changed to the afternoon

Lots of repetition of breathlessness strategies

Recruited volunteers

More discussion regarding improving air quality

Tea and coffee provided

Circular layout

Palliative care discussion embedded into general energy conservation and equipment support

Reduced waiting times

We did

Moved to Portland community hospital

Smoking cessation embedded into other talks

Developed what to expect leaflet

Ongoing QI embedded into programme

Sleep health now included

# Results

Portland	2023/2024	2024/2025	2025/2026
Referrals	86	100	97
Waiting times referral to group start	19.75 weeks	8.6 weeks	6.2 weeks
Completion rates	34%	40%	Estimated – 54%

**Referral to completion  
7 weeks!**

## Improved

- Accessibility
- Time/location/parking/education leaflet
- Education
- Displays/videos/topics
- Volunteers

## Future developments

- What to expect and education videos – QR code
- Drop in's/ newsletters for referrers
- Health fairs – raising awareness
- Embedded QI within programme – Q and A
- How to assess improved self management?

# Keep the Caring, Stop the Strain

Clean Language training  
for healthcare professionals –  
what difference does it make?

Saskie Dorman, Consultant in Palliative Medicine  
Forest Holme Hospice, University Hospitals Dorset NHS Foundation Trust  
Clean Language training provided by Conversaurus and kindly funded by UHD Charities

- 8 palliative care staff
- 2 half-day online workshops
- Questionnaires before and after the training
- Semi-structured interviews

[Using the communication technique of Clean Language in healthcare: an exploratory survey | BMJ Open Quality.](#)



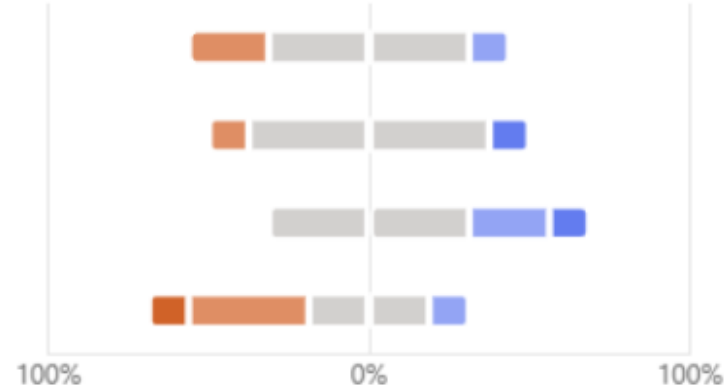
- Responses showed a shift in **communication style**.

*“I would like to have more confidence talking with patients and relatives and how to respond to difficult questions I do not know the answers to”*

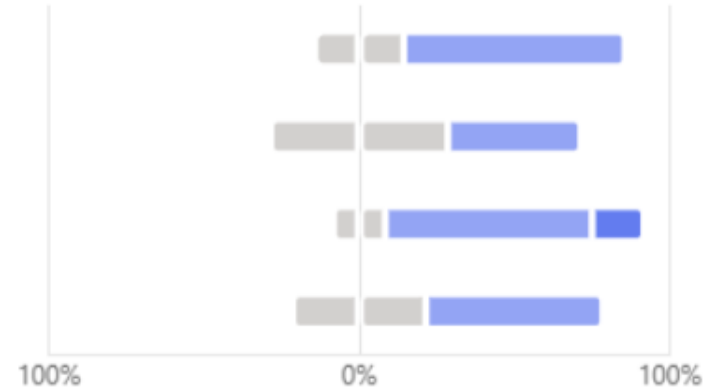
● 1 - Never ● 2 ● 3 ● 4 ● 5 - Very Often

- I help others explore their own thinking without leading them
- I avoid adding my own interpretations when asking questions
- I stay curious about what the other person means rather than assuming I know
- I ask questions using the other person's exact words

**Before training**

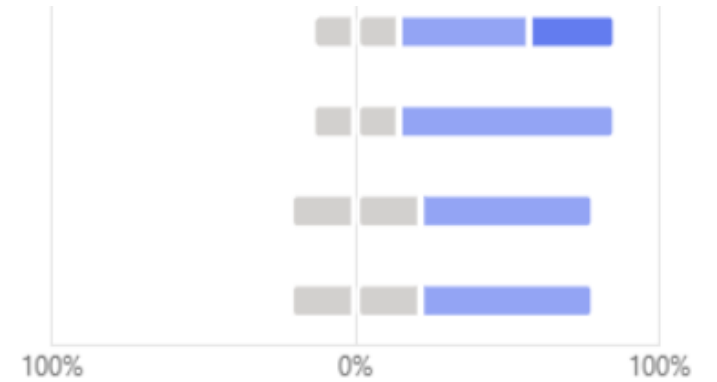


**After training**



- Several participants said that they like to **try out new learning** at work.
- Before the workshops, most did not feel they had time to do so.
- After the training, more participants felt that they had **time and support to try out new learning**.

- In my work, I like to try out new learning
- In my work, I am supported to try out new learning
- In my work, I have time to try out new learning
- In the past 3 months at work, I have tried out something new I have learned



“It was a really helpful course. It **really made me think** about my current communication style and where clean language can fit in.”

“This workshop has made me **take a step back** and look at the elements of communication. In particular the **power of the spoken word** and **how this is received** by another person. It has highlighted the **value of listening and repeating** and how the conversations guide attention.”

“It has **really made me think** about how I communicate with people and also given me **confidence**”

“I think it would be **helpful to everyone**, especially in encouraging **self-awareness**”

“A useful communication style that can work in **every aspect of life.**”

“It has empowered me to **embrace pause** and “awkwardness” that I may previously have tried to fill with my own thoughts and ideas. It has given me **confidence** to know I am doing ok”

## Conclusion

- Clean Language techniques can be useful in healthcare, with impacts on
  - communication style
  - wellbeing at work
  - self-awareness and confidence.
- There's appetite to try out new learning at work – let's make time for it.


- If you're interested to find out more – let's talk...
- [saskie.dorman1@nhs.net](mailto:saskie.dorman1@nhs.net)



**Any Questions?**



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# Improving Malnutrition Universal Screening Tool (MUST) Compliance on Stroke Unit

Hla Hla Aye  
Junior Clinical Fellow  
Royal Bournemouth Hospital  
16/04/2026

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# Background & Clinical Importance

- Malnutrition --> increase morbidity, mortality, length of hospital stay
- Stroke patients --> high risk
  - dysphagia
  - immobility
  - reduced consciousness
  - cognitive impairment
- Malnutrition following stroke --> worse outcomes, delayed rehabilitation, and increased long-term dependency.

# Guidelines & MUST score

- NICE recommendations:
  - Screen within 24 hours of admission
  - Repeat weekly
- MUST includes:
  - BMI
  - Percentage of unintentional weight loss
  - Effect of acute disease on nutritional intake
- Risk categories:
  - Low/ Medium/ High

# Why this Audit?

- Previous audit in 2018 --> lack of follow-up
- No action plan for re-audit or implementation of findings --> improvements cannot be sustained and clinical impact is limited.
- Highlighted the need for a re-evaluation.

# Aim and Standards

## Aims:

- Assess compliance with MUST standards
- Evaluate improvement after intervention

## Standards (Target $\geq 90\%$ ):

- Initial Screening within 24 hours
- Weekly reassessment
- Dietitian referral (MUST  $\geq 2$ )

# Methodology

- 2-cycle audit-based QI using PDSA cycle
- Sample: 100 patients
- Data: Prospective + Retrospective  
Electronic records (eNA)

Assessing compliance against established standards.

Timeframe: July - August 2025 (Cycle 1)

October 25 - January 26 (Cycle 2)

# Results - First Cycle Audit

- Showed:
  - Initial assessment: 100%
  - Weekly reassessment: 93%
  - Dietitian referral: 63% (well below the standard)

## Problems Identified

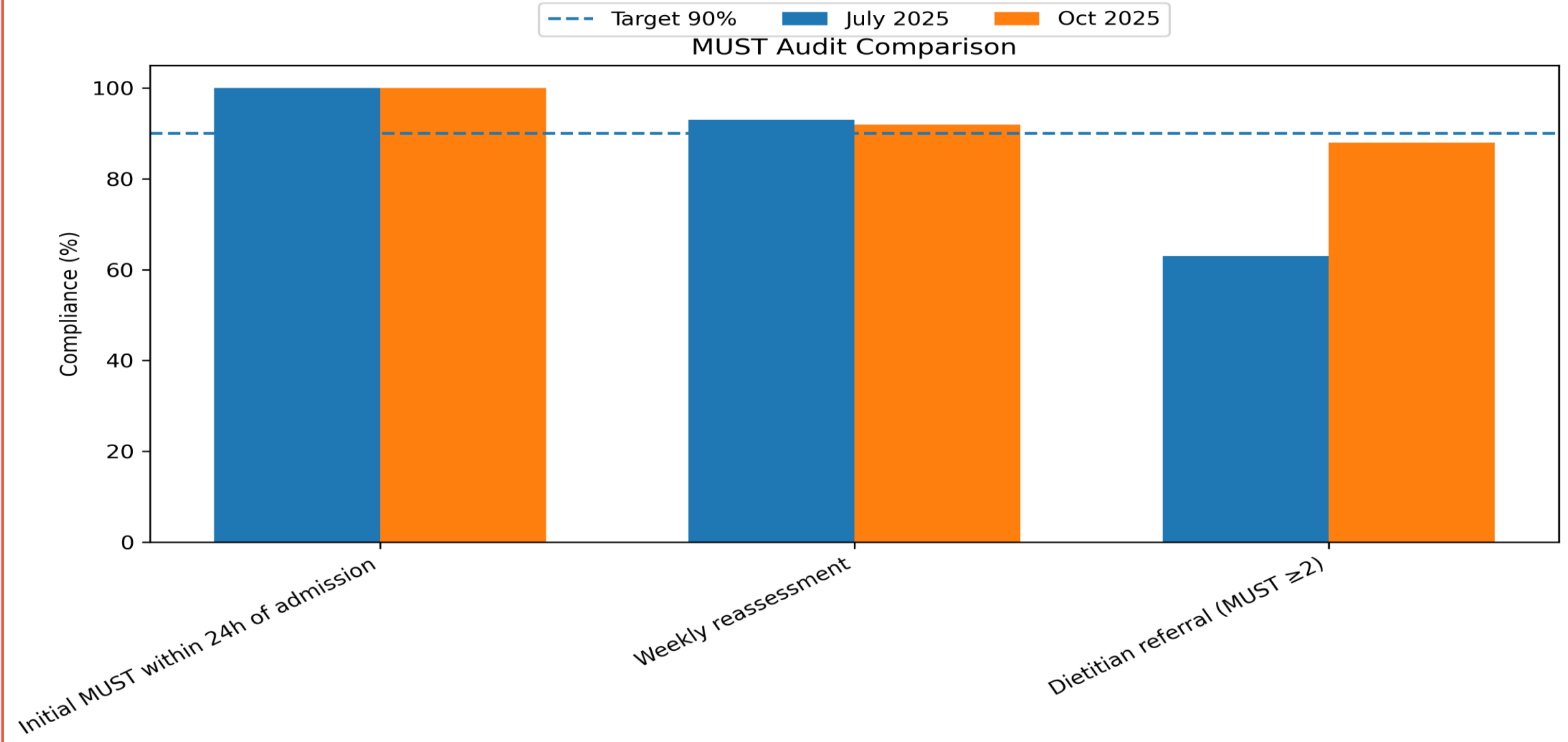
- Missed or delayed referrals to dietitian for MUST  $\geq 2$
- Documentation gaps

## Intervention

- Educational posters
- Quick reference guides
- Staff awareness reinforcement
- Visual prompts in clinical areas

## Re-audit Results (Second Cycle)

- Initial MUST: 100%
- Weekly reassessment: 92%
- Dietitian referral: 88% (increased from 63%)



## Limitations

- Single Unit
- Documentation bias

## Conclusion

- Good screening compliance
- Dietitian referral improved significantly --> intervention worked,  
awareness increased
- Small gaps remain --> requires ongoing monitoring & engagement.

## This project

- highlights the importance of consistent nutritional screening and timely dietitian referral in stroke care.
- demonstrates that simple interventions can lead to meaningful improvements in patient care.
- reinforces the value of continuous audit cycles in sustaining quality improvements aligned with NICE & Trust standards.



THANK

YOU



**Any Questions?**



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# Quality improvement at the front door

The Stroke Team at UHD  
April 2026

# Thrombolysis in Acute Stroke Collaboration



TASC was an NHS Elect programme to improve access to hyper-acute stroke treatments through better pathways and decision-making.



UHD joined the initiative to increase ischaemic stroke thrombolysis rates which had historically been around 11% with significant variability.



We took part in the initiative from Oct 24 to Oct 25 during which time we saw a 40% increase in our thrombolysis rates

# TASC support and resource



Support through QI coaching, webinars and peer learning



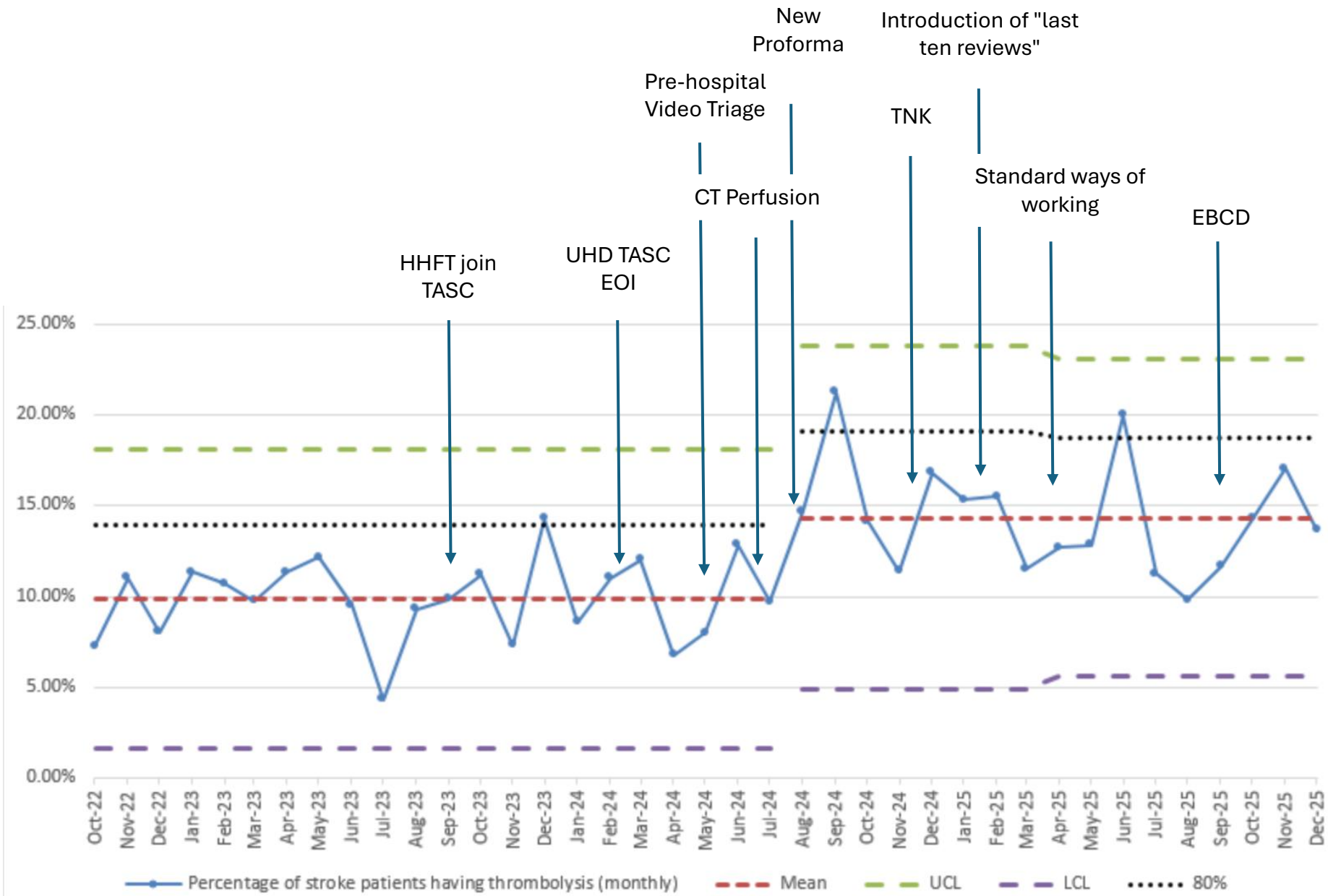
Practical tools such as SPC templates, patient experience resources, and big data modelling tools to help with decision making



Support with conducting a deep dive into our data collection and analysis



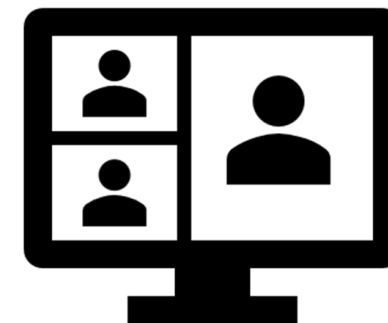
Facilitation of national learning events and communities of practice



# Pre-Hospital Video Triage (PVT)



England

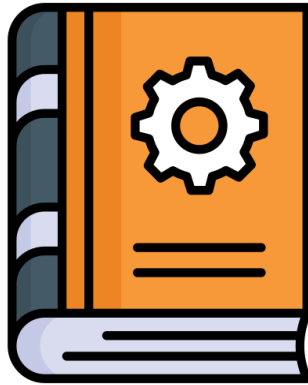


The NHS Long Term Plan and GIRFT recommend pre-hospital telemedicine to boost early specialist stroke assessment, improve diagnostic accuracy, and optimise thrombolysis and thrombectomy pathways.

UHD, SWASFT and DCH collaborated to submit an expression of interest for £100,000 of NHSE funding to pilot pre-hospital video triage across Wessex.”

PVT was launched in May 2024 through the GoodSam platform and enabled real-time video consultations between paramedic crews and stroke clinicians

# PVT Service and Review



All pre-alerts were to be referred via PVT 7 days a week between 7am and 9pm

All "calls" answered by Stroke SSN/ACP's with consultant and reg input as required

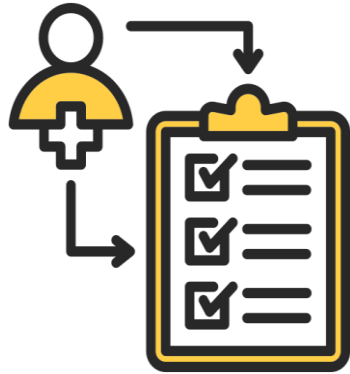


We conducted mid-point analysis of May 2024–Feb 2025 activity, comparing referral volumes, diagnoses, pathway decisions and key timings with traditional telephone pre-alerts

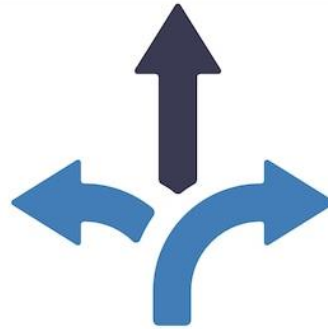


3,901 referrals were made to the stroke service, with 1,419 (36%) pre-alerted prior to hospital arrival. Of these, 329 (25%) were conducted via PVT

# PVT results



PVT matched telephone mimic rates and probably improved key timings, with faster door-to-CT (23 vs 27 min) and door-to-needle times (54 vs 62 min).



PVT enabled earlier, more accurate pathway decisions, reducing direct-to-CT triage (41% vs 61%) and increasing safe diversion away from stroke services five-fold



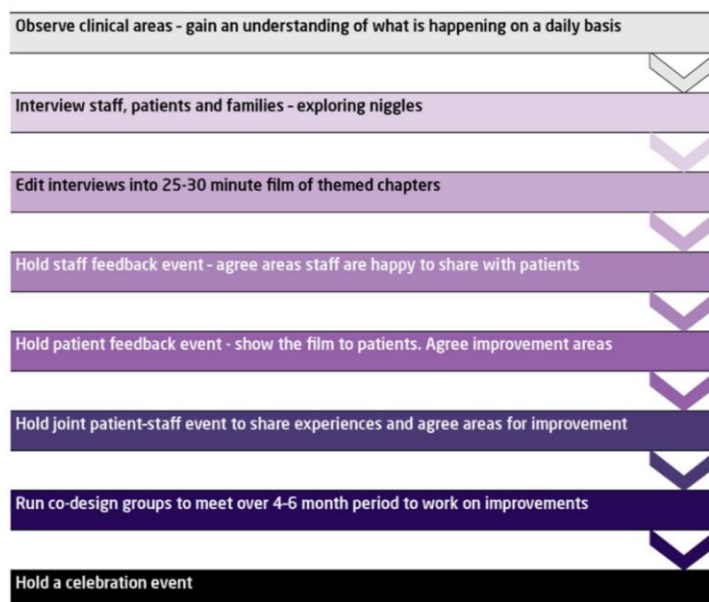
PVT strengthened UHD-SWASFT collaboration, supported pathway redesign, and enabled innovations including enhanced TIA/SDEC models and joint education



# Experience of thrombolysis care

Our approach:

## Stages in Experience Based Co-Design



- Staff survey (what works well, concerns, view of experience)
  - Oct 25
  - Participants = 19
  - Pathway wide
- Multiple roles (stroke team and others)



- Invited patients who were recently thrombolysed to share experience (Sept 25)
  - Volunteers = 3
  - Interviews (Nov 25)
- Whole pathway discussion (1 hour per volunteer), open discovery format, prompts icons related to pathway stages

# Findings: Themes for improvement

## 1. Patient narratives

Communication, but specifically:

- Consenting process (involvement in discussions, understanding of risks & benefits)
- How we involve family/significant others within the pathway
- Post thrombolysis ward conversations (the need for a debrief)

## 2. Staff survey

Generally positive, but less consistent OOH:

- Comparison to day/night service and staffing (need to level up service offer)
- Need for clearer roles and stronger cross team training
- Too much variability in imaging requesting and ED coordination, specifically out of hours

# Next Steps



Feedback learning/themes from survey and interviews with staff.

Recruit staff for co-design meetings



Begin co-design workshops with staff and patients – each workshop will have a focus based on key themes (e.g. consent).

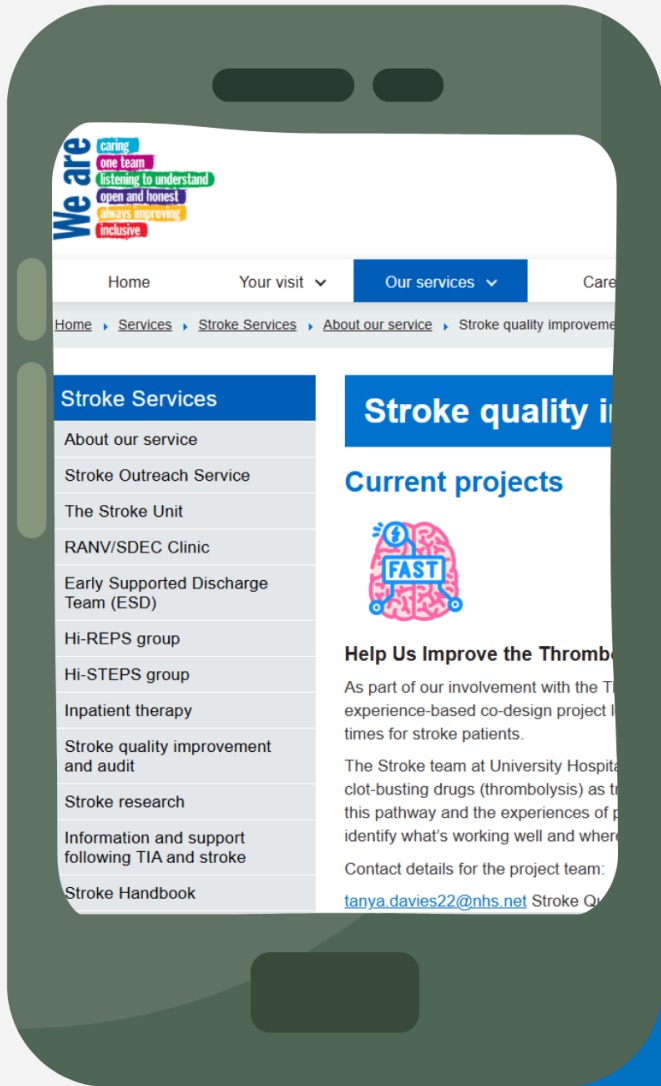
Aim to co-create solutions to improve experience of care



Implement co-designed solutions in practice, evaluate and share learning.

Celebration event with co-design team.





# Interested in our work and want to know more...

please visit our Stroke Quality  
Improvement pages on:



[www.uhd.nhs.uk/services/stroke-services/bournemouth/stroke-qi-audit](http://www.uhd.nhs.uk/services/stroke-services/bournemouth/stroke-qi-audit)





**Any Questions?**



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# PERI-OPERATIVE RISK ASSESSMENT AND SHARED DECISION MAKING IN FRAIL OLDER PEOPLE

## A POPS CLINIC AUDIT

Dr Peter Robinson – Consultant Geriatrician Clinical Lead for POPS

Dr Ian Mowat – Consultant Anaesthetist

Dr Lynsey Woodward – Consultant Anaesthetist

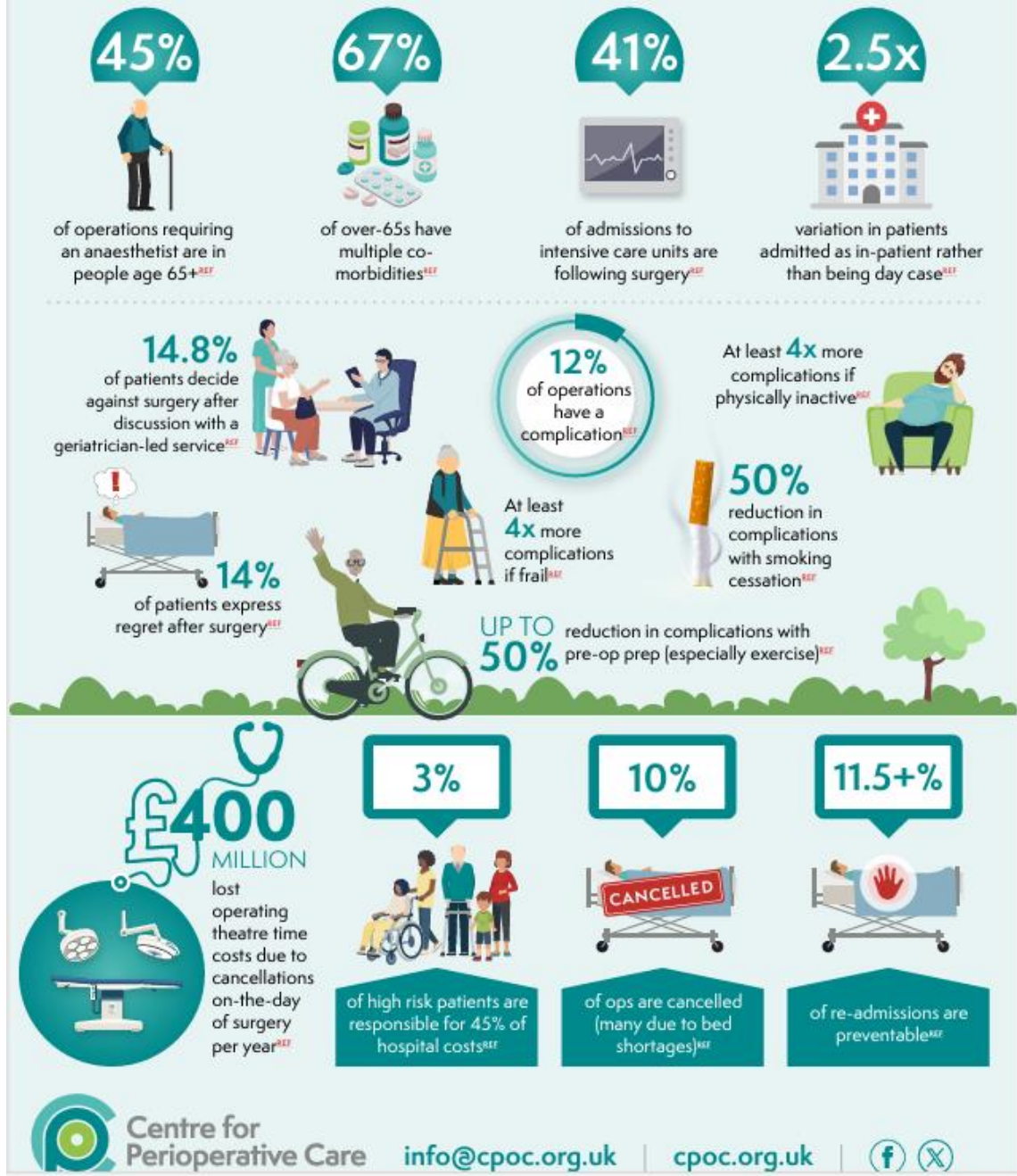
Lucy Scott – Advanced Clinical Practitioner

Laura Gates – Advanced Clinical Practitioner

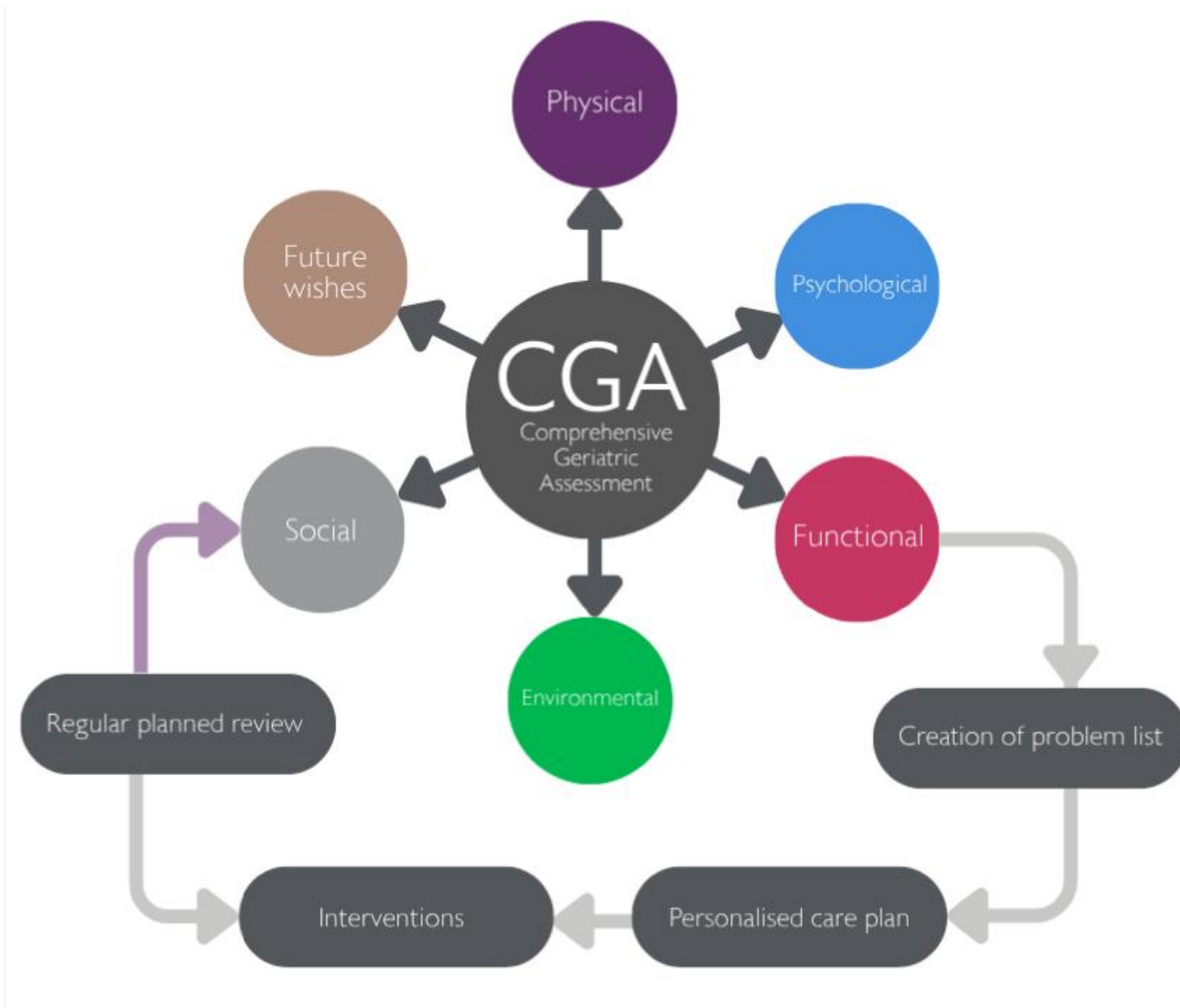
Dr Hannah Judd - Clinical Fellow

David Vincent - Pharmacist





**We are caring one team listening to understand open and honest always improving inclusive**



We are **caring** **one team** **listening to understand** **open and honest** **always improving** **inclusive**

AIMS AND OBJECTIVES	METHODOLOGY
Implementation of Multidisciplinary geriatric peri-operative clinic.	<p>Retrospective Audit over 2 years</p> <p>Referral criteria :</p> <p>Age &gt; 65</p> <p>Clinical risk factors</p> <p>CFS &gt; 4</p>
Improve risk stratification and decision making for frail surgical patients.	<p>Comprehensive geriatric assessment.</p> <p>Structured multi domain assessment.</p>
	<p>Identification of Risk domains.</p>
	<p>Individualized tailored clinical recommendations.</p>
	<p>Optimization of patients on a Surgical intervention Pathway.</p>



RISK DOMAIN FRAILTY FACTORS	POSITIVE FINDINGS %
SARCOPENIA	48 23 (Equivocal)
MALNUTRITION	18
DELIRIUM	70
COGNITIVE IMPAIRMENT:  AMTS MOCA	12 100
FALLS RISK	74

# SHARED DECISION MAKING

It can be daunting having an appointment, but this leaflet will help you to get the most out of yours.

Sometimes there is more than one treatment available.

Here are four questions you might want to think about at your appointment.

**What are the Benefits?**

**What are the Risks?**

**What are the Alternatives?**

**What if I do Nothing?**

If you choose not to have treatment now, it does not mean you cannot change your mind at a later stage. We know circumstances and conditions change.

You can talk with your healthcare professional about how to seek support later if you decide to do nothing now.

You may want to talk over all your options with family or friends. It's also helpful to think about what affect these options will have on you and your lifestyle.

If there is anything you are unsure about, please ask.

Please use this as a reminder to ask questions about treatment.

Make the most of your appointment using the BRAN questions:

What are the **Benefits**?

What are the **Risks**?

What are the **Alternatives**?

What if I do **Nothing**?

ChoosingWisely  
UK



## Make the most of your appointment

Helping you make the right choice using **BRAN**



Benefits



Risks



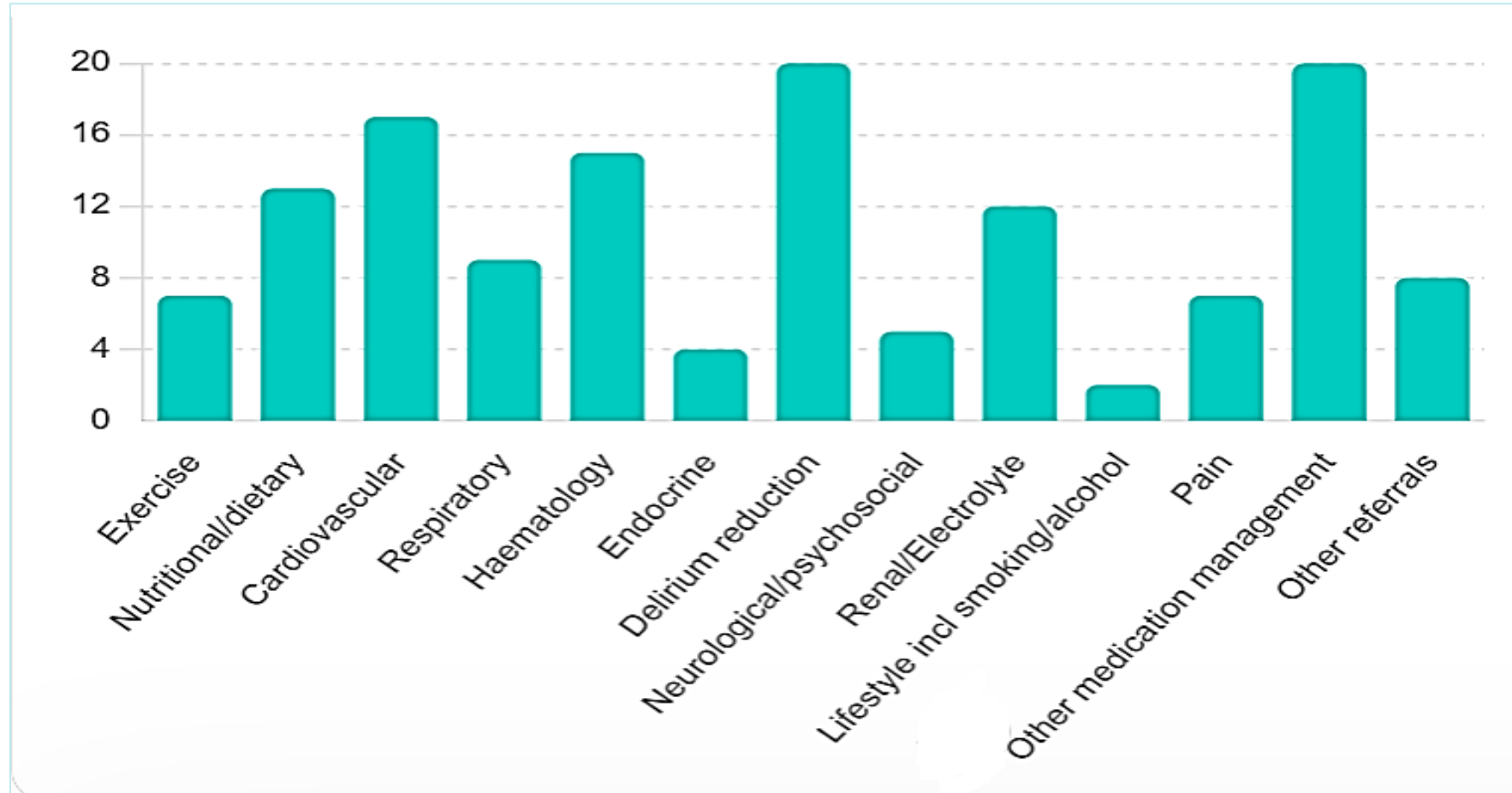
Alternatives



Nothing

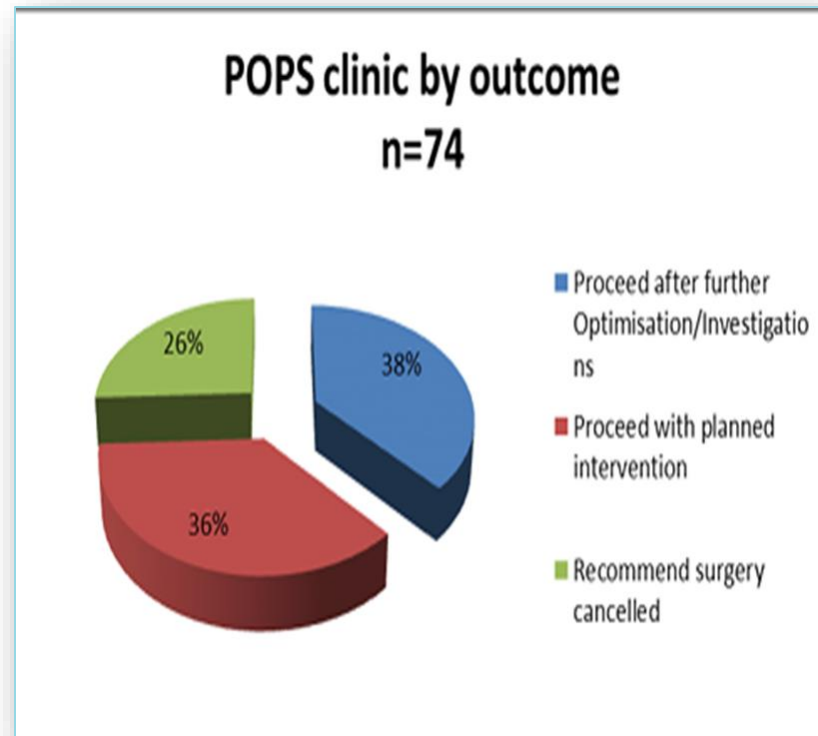
# RECOMMEND PROCEED AFTER FURTHER INTERVENTION

DOMAIN ACTIVITY N =29 (38%)



# CLINIC OUTCOME RECOMMENDATIONS & CONCLUSIONS

- Mean age 80
- Mean CFS 6
- Structured approach to patient assessment is required to produce a multi-domain risk profile.
- There was high prevalence of common frailty syndrome identified.
- 38% (29) continued on their original treatment pathway but with a bespoke set of actions to reduce the risks identified.
- 26% (16) decision was reached after shared decision making discussions not to proceed with the planned surgical intervention



## REFERENCES

- 1. Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery September 2021, Centre for Peri-operative Care
- 2. Choosing Wisely UK. Choosing Wisely UK. London: AOMRC; 2021 (cited 2021 12 August). Available from: [choosingwisely.co.uk/about-choosing-wisely-uk](https://choosingwisely.co.uk/about-choosing-wisely-uk)
- 3. Implementing a system-wide cancer prehabilitation program: The journey of Greater Manchester's 'Prehab4cancer' EUR J Surg Oncol 2021 Mar;47(3 Pt A):524-532. doi: 10.1016/j.ejso.2020.04.042. E pub 2020 May



**Any Questions?**



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LUNCH